

SERFF Tracking Number: MCHX-G127678771 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 49936  
 Company Tracking Number: IA-006 (Ed. 09-11)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 09-11) Indiv Life Application - Harley  
 Project Name/Number: IA-006 (Ed. 09-11) Indiv Life Application - Harleysville Life Insurance Company/IA-006 (Ed. 09-11) Indiv Life Application - Harleysville Life Insurance Company

## Filing at a Glance

Company: Harleysville Life Insurance Company

Product Name: IA-006 (Ed. 09-11) Indiv Life Application - Harley	SERFF Tr Num: MCHX-G127678771	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49936
Sub-TOI: L08.000 Life - Other	Co Tr Num: IA-006 (ED. 09-11)	State Status: Approved-Closed
Filing Type: Form	Author: SPI McHughConsulting	Reviewer(s): Linda Bird
	Date Submitted: 10/03/2011	Disposition Date: 11/09/2011
		Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

## General Information

Project Name: IA-006 (Ed. 09-11) Indiv Life Application - Harleysville Life Insurance Company Status of Filing in Domicile: Pending

Project Number: IA-006 (Ed. 09-11) Indiv Life Application - Harleysville Life Insurance Company Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: SPI McHughConsulting

Filing Description:

HARLEYSVILLE LIFE INSURANCE COMPANY

NAIC # 64327, FEIN # 23-1580983

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/09/2011

State Status Changed: 10/07/2011

Created By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Individual Life Insurance Application Filing

Form IA-006 (Ed. 09-11), Application for Individual Life Insurance

Form IA-007 (Ed. 09-11), Proposed Other Insured Supplement

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Harleysville Life Insurance Company  
Form IA-008 (Ed. 09-11), Children's Insurance Supplement

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Harleysville Life Insurance Company. We respectfully attach an authorization letter for your files.

We are attaching the above-captioned filing for your review and approval for Harleysville Life Insurance Company. The forms are being submitted in final printed form subject only to changes in font style, margins, page numbers, ink, and paper stock. For example, formatting may change slightly when the document is assembled through an automated document assembly system. Printing standards will never be less than those required by law.

Forms IA-006 (Ed. 09-11), IA-007 (Ed. 09-11) and IA-008 (Ed. 09-11) will respectively replace forms IA-006 (Ed. 08-10), IA-007 (Ed. 08-10) and IA-008 (Ed. 08-10) which were previously approved by your Department on October 26, 2010 under SERFF Tracking Number MCHX-G126868655.

The Application for Individual Life Insurance originally contained a signature and authorization section at the end of Part I, this has been removed. The signature and authorization section remains at the end of Part II as these two parts of the application will always be used together. There were also minor adjustments made to all three forms that were intended to clarify and simplify the medical and lifestyle questions.

Attached are any required certifications, transmittal forms and/or filing fees.

While every effort is made to submit filings without mistakes, we reserve the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

We trust the attached is found to be in order and look forward to receiving your favorable reply. Should you have any questions or if we may provide any additional information, please do not hesitate to contact the undersigned. Thank you for your consideration in this matter.

Very truly yours,

Linda Boyce  
Consultant

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Attachments

## Company and Contact

### Filing Contact Information

Jackie Tootchen, Compliance Project Team Leader mcr@mchughconsulting.com

McHugh Consulting Resources, Inc. 215-230-7960 [Phone]  
 2005 South Easton Road, Suite 207 215-230-7961 [FAX]  
 Doylestown, PA 18901

### Filing Company Information

(This filing was made by a third party - McHughConsulting)

Harleysville Life Insurance Company	CoCode: 64327	State of Domicile: Pennsylvania
355 Maple Avenue	Group Code: 253	Company Type: Life
Harleysville, PA 19438	Group Name:	State ID Number:
(215) 393-6118 ext. [Phone]	FEIN Number: 23-1580983	

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$150.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Harleysville Life Insurance Company	\$150.00	10/03/2011	52398644

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/09/2011	11/09/2011
Approved-Closed	Linda Bird	10/07/2011	10/07/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Individual Life Insurance	SPI McHughConsulting	11/09/2011	11/09/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to Reopen	Note To Filer	Linda Bird	11/09/2011	11/09/2011
Request to Reopen	Note To Reviewer	SPI McHughConsulting	11/08/2011	11/08/2011

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## Disposition

Disposition Date: 11/09/2011

Implementation Date:

Status: Approved-Closed

Comment: Correction made on the Individual application form IA-006 (Ed.a0.09).

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	AR Compliance - Rule 49		Yes
Supporting Document	AR Compliancer Rule 19		Yes
Supporting Document	GAN-009 (AR) (Ed. 01-04)		Yes
Supporting Document	LFEA-138 (Ed. 10-09)		Yes
Form (revised)	Application for Individual Life Insurance		Yes
Form	Application for Individual Life Insurance	Replaced	Yes
Form	Proposed Other Insured Supplement		Yes
Form	Children's Insurance Supplement		Yes

SERFF Tracking Number: MCHX-G127678771 State: Arkansas  
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## Disposition

Disposition Date: 10/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Supporting Document	Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	AR Compliance - Rule 49		Yes
Supporting Document	AR Compliancer Rule 19		Yes
Supporting Document	GAN-009 (AR) (Ed. 01-04)		Yes
Supporting Document	LFEA-138 (Ed. 10-09)		Yes
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Form	Application for Individual Life Insurance	Replaced	Yes
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**Amendment Letter**

Submitted Date: 11/09/2011

**Comments:**

Thank you for reopening this filing.

We would like to replace the originally filed form IA-006 (Ed. 09-11) with this updated version as we inadvertently left out the Agent replacement question information found in the Agent Certification section on the last page of this form.

Ashley Schute  
 McHugh Consulting Resources, Inc.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
IA-006 (Ed. 09-11)	Application/EApplication nrollment Form	Application for Individual Life Insurance	Revised				51.000	IA-006 (Ed 09-11) App for Life Ins - Basic-updated 11_8_11.PDF

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**Note To Filer**

**Created By:**

Linda Bird on 11/09/2011 08:04 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

11/09/2011 08:04 AM

**Subject:**

Request to Reopen

**Comments:**

Filing has been re-opened in order for correction to be made.

*SERFF Tracking Number:* MCHX-G127678771                      *State:* Arkansas  
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**Note To Reviewer**

**Created By:**

SPI McHughConsulting on 11/08/2011 03:24 PM

**Last Edited By:**

SPI McHughConsulting

**Submitted On:**

11/08/2011 03:24 PM

**Subject:**

Request to Reopen

**Comments:**

We would like to replace the originally filed form IA-006 (Ed. 09-11) with this updated version as we inadvertently left out the Agent replacement question information found in the Agent Certification section on the last page of this form.

Regards

Ashley Schute

McHugh Consulting Resources, Inc.

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	IA-006 (Ed. 09-11)	Application/Enrollment Form	Application for Individual Life Insurance	Revised	Replaced Form #: Previous Filing #:	51.000	IA-006 (Ed 09-11) App for Life Ins - Basic-updated 11_8_11.PDF
	IA-007 (Ed. 09-11)	Application/Enrollment Form	Proposed Other Insured Supplement	Initial		50.000	IA-007 (Ed_09-11) Prop Other Ins Supp- Basic final 9_30_11.PDF
	IA-008 (Ed. 09-11)	Application/Enrollment Form	Children's Insurance Supplement	Initial		48.000	IA-008 (Ed_09-11) Child Ins Supp- Basic final 9_30_11.PDF



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

**Part I APPLICATION FOR INDIVIDUAL LIFE INSURANCE**

**Section I Proposed Primary Insured**

1. Full Name:

_____	_____	_____	_____ / _____	_____	_____
Last	First	M.I.	Birth Date / Birth State	Sex	Marital Status
Former name if changed in the last 5 years: _____					
_____	_____	_____	_____	_____	_____
Last	First	M.I.	Social Security Number	Driver's License #/State	
Residence: _____					
_____			_____	_____	
Street and Number or Rural Route			Telephone #	Cell Phone #	
_____	_____	_____	_____		
City	State	Zip Code	Email Address		

2. Occupation: \_\_\_\_\_  
 Work Phone Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Type of Business: \_\_\_\_\_  
 Annual Income: \$ \_\_\_\_\_  
 Total Net Worth: \$ \_\_\_\_\_

3. U. S. Citizen  Yes  No  
 If No, Date of Entry to U.S. \_\_\_\_\_  
 Visa Type \_\_\_\_\_  
 Country of Citizenship \_\_\_\_\_

4. Have you ever used tobacco or nicotine products in any form?  Yes  No

If Yes, please provide details:

Product	Date Last Used (month/year)	Amount/Frequency
Cigarettes	_____	_____
Cigar/Pipe	_____	_____
Chewing Tobacco	_____	_____
Other: _____	_____	_____

**Section II Beneficiary Information**

1. (Name and Relationship, % share of proceeds, age if minor, SS # and/or Date of Birth)

Primary: \_\_\_\_\_ Contingent: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Section III Owner Information (Owner is Proposed Primary Insured, if not otherwise stated.)**

1. Name of Owner: \_\_\_\_\_  
 Owner's Social Security Number or Tax ID # : \_\_\_\_\_  Proposed Primary Insured becomes Owner at age 21. (check if applicable)  
 Owner's Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Street and Number or Rural Route  
 \_\_\_\_\_  
 City State Zip Code

2. Trust Information (Please complete if policy owner is a trust.)  
 Name of Trust: \_\_\_\_\_ Name of Trustee: \_\_\_\_\_  
 Date of Trust: \_\_\_\_\_ Trust Identification Number: \_\_\_\_\_

**Section IV Payment**

1. Payor (If other than the Proposed Primary Insured) \_\_\_\_\_

2. Billing Address:  Residence  Business  Owner  
 \_\_\_\_\_  
 Street and Number or Rural Route City State Zip Code

3. Premiums are to be Paid (choose one) Planned Premium \$ \_\_\_\_\_  
 Annually  Semi-Annually  Quarterly  Single Premium (UL and WL only)  9-Pay (Term only)  
 PAC \* [  Credit Card- except for first premium payment ]  
 \* Pre-Authorized Check; also requires completed PAC form, void check and 2 months premium.

**Section V Plan of Insurance**

1. What plan are you applying for?  Term  Universal Life  Whole Life (If applying for more than one, check all that apply) Complete the section(s) below for each plan(s) that you are applying for.

**a) Term Life**

Level Term: Length of Term  10  15  20  30

Amount of Insurance: \_\_\_\_\_ (Please complete the Financial Information Questionnaire if amount

Riders: (choose all that are applicable) \_\_\_\_\_ is over \$1,500,001 or more)

Children's Benefit, Amount \$ \_\_\_\_\_ (Please complete the Children's Insurance Supplement)

Other Insured, Amount \$ \_\_\_\_\_ (Please complete the Proposed Other Insured Supplement)

Waiver of Premium ]

**b) Whole Life**

Amount of Insurance: \_\_\_\_\_ (Please complete the Financial Information Questionnaire if amount

Riders: (choose all that are applicable) \_\_\_\_\_ is \$1,500,001 or more)

[  Accidental Death Benefit, Amount \$ \_\_\_\_\_

Automatic Premium Loan

Children's Benefit, Amount \$ \_\_\_\_\_ (Please complete Children's Insurance Supplement)

Guaranteed Insurability Benefit, Amount \$ \_\_\_\_\_

Payor Benefit (Please complete Payor Benefit Supplement)

Waiver of Premium ]

**c) Universal Life**

Plan of Insurance: \_\_\_\_\_

Amount of Insurance \_\_\_\_\_ (Please complete the Financial Information Questionnaire if amount

**Death Benefit Option** (choose one) \_\_\_\_\_ is \$1,500,001 or more)

Option 1: Death Benefit equals Specified Amount

Option 2: Death Benefit equals Specified Amount + Cash Value

**No-Lapse Guarantee Minimum Premium Option** (choose one)

10 Years

20 Years

30 yr NLG

NLG to 100

Maturity

Other: \_\_\_\_\_ ]

**Riders:** (choose all that are applicable)

Accidental Death Benefit, Amount \$ \_\_\_\_\_

Children's Term Insurance, Amount \$ \_\_\_\_\_ (Please complete Children's Insurance Supplement)

Other Insured, Amount \$ \_\_\_\_\_  All Years  Number of Years \_\_\_\_\_ (Please complete Proposed Other

Accidental Death Benefit - Other Insured, Amount \$ \_\_\_\_\_ Insured Supplement)

Primary Insured, Amount \$ \_\_\_\_\_  All Years  Number of Years \_\_\_\_\_

Scheduled Increase Option, Amount \$ \_\_\_\_\_

Total Disability Premium Payment

Waiver of Monthly Deductions (not available if Total Disability Premium Rider selected)

Other \_\_\_\_\_ ]

**Section VI Pending Life Applications**

1. Have you applied for or do you have any other applications or informal inquiries for life insurance pending with any other companies?  Yes  No If Yes, please provide details:

**Name of Company**

**Amount of Coverage**

**Purpose**

\_\_\_\_\_

\_\_\_\_\_

Which pending applications do you intend to accept? \_\_\_\_\_

2. Have you ever had an application or reinstatement request for life, health or disability insurance declined, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium?  Yes  No

If Yes, please provide details: \_\_\_\_\_

3. Do you intend to sell or permanently assign the policy to another person, entity, life settlement provider or investor, or will it replace a policy that has already been sold to another life settlement company or investor?  Yes  No

If Yes, please complete and submit a **Stranger Owned Life Insurance/Life Settlement Questionnaire**.

**Section VII Other Insurance In Force**

1. Do you have existing life insurance policies or annuity contracts?  Yes  No

Is the insurance applied for intended to replace any life Insurance policies or annuity contracts?

If Yes, Please complete the following:

COMPANY	AMOUNT	YEAR ISSUED	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Yes  No  
 Yes  No  
 Yes  No

2. Harleysville Life Policy to be converted:

Existing policy # \_\_\_\_\_ Conversion Amount  Full  Partial \$ \_\_\_\_\_

If partial conversion, status of remaining coverage  
 Retain: Amount: \$ \_\_\_\_\_  
 Terminate Balance of Term Coverage

**Section VIII General Information**

1. In the past/next 2 years have you or do you intend to travel to a foreign country for reasons other than vacation? <b>If Yes, please complete Foreign Travel Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer? <b>If Yes, please complete Foreign Residence Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports <b>If Yes, please complete the appropriate questionnaire(s)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license? <b>If Yes, please complete an appropriate Aviation Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol? <b>If Yes, please complete the appropriate Alcohol or Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 7 years, have you filed for bankruptcy? <b>If Yes, please provide details including chapter filed, date, reason and if discharged</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future? <b>If Yes, please complete the Military Status Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on probation or parole? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details to questions above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Part II Medical Information**

1. Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight change ( > 10 lbs) in last 12 months \_\_\_\_\_ Reason for weight change \_\_\_\_\_  
 Personal Primary Physician: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Specialty Physician(s)  Yes  No (Please provide physician(s) information to the detail section on the next page.)

**2. To the best of your knowledge and belief, has a parent or sibling died of coronary artery disease, cerebrovascular disease, diabetes mellitus, or cancer?**

Relationship	Age at Death	Cause of Death
Father		
Mother		
Brothers and Sisters		

**3. Have you ever been diagnosed with, been treated for or consulted a physician for:**  
 (If Yes, please provide full details)

a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. seizures, tremors, migraine headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. albumin, blood or protein in the urine or any other disorder of the kidney or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. sexually transmitted disease or any other disorder of the uterus, cervix, ovaries, breast, prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. arthritis or any other disorder of the bones, joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. any disorder of the eyes, ears, nose, throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. any disease or disorder other than what is mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No



**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I (We) authorize any licensed physician, medical practitioner, hospital, clinic, dispensary, sanitarium, or other medically related facility, governmental motor vehicle agencies, insurance companies, the Veteran's Administration, Medical Information Bureau (MIB, Inc.), pharmaceutical data bases, consumer reporting agency or employer to release to the Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me (us) or my children if they are to be insured: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation, habits, driving record and general character. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance. In addition to this Authorization, and to facilitate rapid transmission of information to an appropriate Harleysville representative(s), I (We) will execute Authorizations for Release of Medical Records for any sources requiring an authorization.

I (We) understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

I (We) authorize;  I (We) do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record.

I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I (We) certify that the Social Security Number(s) provided above is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

I (We) request;  I (We) do not request, a personal interview in connection with such report.

I (We) understand and acknowledge that this application and all supplementary documentation, in the aggregate, constitute the entire application, including all information provided in the application, the medical exam, questionnaires and supplements to the application, and amendments issued by Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy and delivered to the policy owner.

I (We) have paid \$\_\_\_\_\_ with this application in consideration of the Temporary Insurance Agreement. I (We) have read, understood, and agreed to the terms of the Temporary Insurance Agreement.

SIGNED AT: \_\_\_\_\_  
**City and State**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

P \_\_\_\_\_  
**Signature of Owner** (if other than Insured)

P \_\_\_\_\_  
**Signature of Insured**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Applicant** (if other than Insured)

**AGENT CERTIFICATION**

I certify that I personally completed this application in the company of all proposed insureds.  Yes  No  
I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.  Yes  No

Does the proposed insured have existing life insurance policies or annuity contracts?  Yes  No  
Is this insurance applied for intended to replace any existing life insurance policies or annuity contracts?  Yes  No  
If either question is answered Yes, please complete a replacement form as prescribed by your state's regulations.  
Is this a 1035 Exchange?  Yes  No      Is this an internal term conversion?  Yes  No

Signed at: \_\_\_\_\_  
Dated on: \_\_\_\_\_

P \_\_\_\_\_  
**Signature of Licensed Agent**  
Ü \_\_\_\_\_  
**Print Name of Licensed Agent**



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

**Proposed Other Insured Supplement**

**Section I Proposed Other Insured**

1. Relationship to Proposed Insured: \_\_\_\_\_

Full Name: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_  
 Last First M.I. Birth Date Birth State Sex Marital Status

Former name if changed in the last 5 years: \_\_\_\_\_

\_\_\_\_\_  
 Last First M.I. Social Security Number Driver's License#/State

Residence:  Same as Primary Insured

\_\_\_\_\_  
 Street and Number or Rural Route Telephone # Cell Phone #

\_\_\_\_\_  
 City State Zip Code Email Address

2. Occupation: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Type of Business: \_\_\_\_\_

Annual Income: \$ \_\_\_\_\_

Net Worth \$ \_\_\_\_\_

3. U. S. Citizen  Yes  No  
 If No, Date of Entry to U.S. \_\_\_\_\_  
 Visa Type \_\_\_\_\_  
 Country of Citizenship \_\_\_\_\_

4. Have you ever used tobacco or nicotine products in any form?  Yes  No

If Yes, please provide details:

Product	Date last used (month/year)	Amount/Frequency
Cigarettes	_____	_____
Cigars/Pipe	_____	_____
Chewing Tobacco	_____	_____
Other: _____	_____	_____

**Section II Beneficiary Information**

1. (Name and Relationship, % share of proceeds, age if minor, SS # and/or Date of Birth)

Primary: \_\_\_\_\_ Contingent: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Section III Other Insurance In Force**

1. Have you applied for or do you have any other applications or informal inquiry for life insurance pending with any other companies?  Yes  No If Yes, please provide details:

Name of Company	Amount of Coverage	Purpose
_____	_____	_____
_____	_____	_____

Which pending applications do you intend to accept? \_\_\_\_\_

2. Have you ever had an application or reinstatement request for life, health or disability insurance declined, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium?  Yes  No

If Yes, please provide details \_\_\_\_\_

3. Do you have existing life insurance policies or annuity contracts?  Yes  No

If Yes, please complete the following:

Is the insurance applied for intended to replace any life Insurance policies or annuity contracts?

COMPANY	AMOUNT	POLICY #	YEAR ISSUED	PURPOSE	
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Do you intend to sell or permanently assign the policy to another person, entity, life settlement provider or investor, or will it replace a policy that has already been sold to another life settlement company or investor?  Yes  No

If Yes, please complete and submit a **Stranger Owned Life Insurance/Life Settlement Questionnaire**.

<b>Section IV General Information</b>	
1. In the past/next 2 years have you or do you intend to travel to a foreign country for reasons other than vacation? <b>If Yes, please complete Foreign Travel Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer? <b>If Yes, please complete Foreign Residence Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports <b>If Yes, please complete the appropriate questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license? <b>If Yes, please complete an appropriate Aviation Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol? <b>If Yes, please complete the appropriate Alcohol or Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 7 years, have you filed for bankruptcy? <b>If Yes, please provide details including chapter filed, date, reason and if discharged</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future? <b>If Yes, please complete the Military Status Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or are you currently on probation or parole? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Section V Medical Information</b>
1. Name of Proposed Other Insured _____ Date of Birth _____ Height _____ Weight _____ Weight change ( > 10 lbs) in last 12 months _____ Reason for weight change _____ Personal Primary Physician: Name: _____ Address: _____ Telephone Number: _____ Specialty Physician(s) <input type="checkbox"/> Yes <input type="checkbox"/> No (Please provide physician(s) information in the details section on the next page.)

<b>2. To the best of your knowledge and belief, has a parent or sibling died of coronary artery disease, cerebrovascular disease, diabetes, mellitus or cancer?</b>		
Relationship	Age at Death	Cause of Death
Father		
Mother		
Brothers and Sisters		

<b>3. Have you ever been diagnosed with, been treated for, or consulted a physician for: (If Yes, please provide full details)</b>	
a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. seizures, tremors, migraine headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No

f. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. albumin, blood or protein in the urine or any other disorder of the kidney or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. sexually transmitted disease or any other disorder of the uterus, cervix, ovaries, breast, prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. arthritis or any other disorder of the bones, joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. any disease or disorder other than what is mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>4. In the past 5 years have you:</b>	
a. had a complete physical exam, or checkup, electrocardiogram, x-ray, blood test, or other diagnostic test (excluding an HIV or AIDS test)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been treated, examined or consulted a physician for a condition other than what has already been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. been advised by a medical professional to have hospitalization, surgery, biopsy, medical treatment or any other diagnostic test (excluding an HIV or AIDS test), which has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. taken or been advised by a medical professional to take a prescription medication, or any herbal or non prescription medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. received disability benefits, been unable to perform routine activities of daily living, or confined to a home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had a member of the medical profession diagnose or prescribe treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or advise that you tested Human Immunodeficiency Virus (HIV) positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been advised by a medical professional to reduce or discontinue the use of alcohol, joined an organization or received medical treatment or counseling for the use of alcohol? <b>If Yes, please complete an Alcohol Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever used barbiturates, amphetamines, cocaine, marijuana or other illegal or controlled substances, except as prescribed by a physician, or joined an organization or received medical treatment or counseling for the use of drugs? <b>If Yes, please complete a Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been advised by a medical professional to reduce or discontinue the use of, or been addicted to, prescription medication? <b>If Yes, please complete a Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Details to any above questions answered Yes.**

Question #	Date(s)	Physician(s)	Details

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

### APPLICANT'S STATEMENT

I (We) have read the preceding questions and answers, and hereby represent that to the best of my (our) knowledge and belief, that the statements and answers are complete and true, and that Harleysville Life Insurance the Company may rely on the answers in the issuance of a policy. I (We) understand and agree that this application and other required parts will be the basis for, and an integral part of, any policy issued; that no waiver or modification will bind the Company unless in writing and signed by the President, or a Vice President or the Secretary of Harleysville Life Insurance Company. I (We) understand and agree that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy or receipt. I (We) further understand and agree; and that **no insurance will take effect unless and until the policy has been manually delivered to and received and accepted by me (us), and the full first premium is paid during the lifetime and of each person on whom insurance is requested and while the proposed other insured is alive.**

### AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I (We) authorize any licensed physician, medical practitioner, hospital, clinic, dispensary, sanitarium, or other medically related facility, governmental motor vehicle agencies, insurance companies, the Veteran's Administration, or Medical Information Bureau (MIB, Inc.), pharmaceutical data bases, consumer reporting agency or employer to release to the Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me (us) or my children if they are to be insured: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation, habits, driving record and general character. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance. In addition to this Authorization, and to facilitate rapid transmission of such information to an appropriate Harleysville representative(s), I (We) will execute the required Authorizations for Release of Medical Records for any such sources requiring an authorization., except Medical Information Bureau (MIB, Inc.), to provide such records of information to any appropriate Harleysville representative(s).

I (We) understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other life insurance companies with which I have policies or to whom I may apply, or to whom a claim for benefits may be submitted; other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

I (We) authorize;  I (We) do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record.

I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I (We) certify that the Social Security Number(s) provided above is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

I (We) request;  
 I (We) do not request, a personal interview in connection with such report.

I (We) understand and acknowledge that this application, and all supplementary documentation, in the aggregate, constitute the entire application, including all information provided in the application, the medical exam, questionnaires and supplements to the application, and amendments issued by the Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy and delivered to the policy owner.

I (We) have paid \$ \_\_\_\_\_ with this application in consideration of the Temporary Insurance Agreement. I (We) have read, understood, and agreed to the terms of the Temporary Insurance Agreement.

SIGNED AT: \_\_\_\_\_  
**City and State**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

P \_\_\_\_\_  
**Signature of Owner** (if other than Insured)

P \_\_\_\_\_  
**Signature of Insured**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Applicant** (if other than Insured)

**AGENT CERTIFICATION**

I certify that I personally completed this application in the company of all proposed insureds.  Yes  No  
I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.  Yes  No

Does the proposed insured have existing life insurance policies or annuity contracts?  Yes  No  
Is this insurance applied for intended to replace any existing life insurance policies or annuity contracts?  Yes  No  
If either question is answered Yes, please complete a replacement form as prescribed by your state's regulations.  
Is this a 1035 Exchange?  Yes  No      Is this an internal term conversion?  Yes  No

Signed at: \_\_\_\_\_

P. \_\_\_\_\_  
**Signature of Licensed Agent**

Dated on: \_\_\_\_\_

\_\_\_\_\_  
**Print Name of Licensed Agent**



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

**Children's Insurance Supplement**

**Section I**

1. List all children to be covered:

Name	Sex	Date of Birth	Height	Weight

**Section II**

1. Is there currently other life insurance policies or annuity contracts in force on any child?  Yes  No  
 If Yes, please provide details: \_\_\_\_\_
2. Is the insurance applied for intended to replace any existing life insurance policies or annuity contracts?  Yes  No
3. Have you ever had an application or reinstatement request for life, health, disability insurance declined, postponed, limited, withdrawn or cancelled, or been asked to pay a higher premium for any child?  Yes  No  
 If yes, please provide details \_\_\_\_\_
4. Amount of life insurance on parents? Father \_\_\_\_\_ Mother \_\_\_\_\_

**Section III General Information**

1. In the past/next 2 years have you or do you intend to travel to a foreign country for reasons other than vacation? <b>If Yes, please complete Foreign Travel Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer? <b>If Yes, please complete Foreign Residence Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports <b>If Yes, please complete the appropriate questionnaire(s)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license? <b>If Yes, please complete an appropriate Aviation Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol? <b>If Yes, please complete the appropriate Alcohol or Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future? <b>If Yes, please complete the Military Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or are you currently on probation or parole? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section IV Medical Information**

1. Child's Personal Primary Physician: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Specialty Physician(s)  Yes  No (Please provide physician(s) information in the details section on the next page.)

<b>2. Has any child ever been diagnosed with, been treated for or consulted a physician for: (If Yes, please provide full details)</b>	
a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. seizures, tremors, migraine headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. albumin, blood or protein in the urine or any other disorder of the kidney or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. sexually transmitted disease or any other disorder of the uterus, cervix, ovaries, breast, prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. arthritis or any other disorder of the bones, joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. any disorder of the eyes, ears, nose, throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. any disease or disorder other than what is mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3. In the past 5 years has any child:</b>	
a. had a complete physical exam, or checkup, electrocardiogram, x-ray, blood test, or other diagnostic test (excluding an HIV or AIDS test)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been treated, examined or consulted a physician for a condition other than what has already been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. been advised by a medical professional to have hospitalization, surgery, biopsy, medical treatment or any diagnostic test (excluding an HIV or AIDS test), which has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. taken or been advised by a medical professional to take prescription medication, or any herbal or non prescription medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. been unable to perform routine activities of daily living?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any child, had a member of the medical profession diagnose or prescribe treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or advise that they tested Human Immunodeficiency Virus (HIV) positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any child ever been advised by a medical professional to reduce or discontinue the use of alcohol, joined an organization or received medical treatment for the use of alcohol? <b>If Yes, please complete an Alcohol Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has any child ever used barbiturates, amphetamines, cocaine, marijuana or other illegal or controlled substances, except as prescribed by a physician, or joined an organization or received medical treatment or counseling for the use of drugs? <b>If Yes, please complete a Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any child ever been advised by a medical professional to reduce or discontinue the use of, or been addicted to, prescription medication? <b>If Yes, please complete a Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No



I (We) understand and acknowledge that this application and all supplementary documentation, in the aggregate, constitute the entire application, including all information provided in the application, the medical exam, questionnaires and supplements to the application, and amendments issued by Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy and delivered to the policy owner.

I (We) have paid \$ \_\_\_\_\_ with this application in consideration of the Temporary Insurance Agreement. I (We) have read, understood, and agreed to the terms of the Temporary Insurance Agreement.

SIGNED AT: \_\_\_\_\_  
**City and State**

P \_\_\_\_\_  
**Signature of Insured**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Owner** (if other than Insured)

P \_\_\_\_\_  
**Signature of Applicant** (if other than Insured)

**AGENT CERTIFICATION**

I certify that I personally completed this application in the company of all proposed insureds.  Yes  No

I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.  Yes  No

Does the proposed insured have existing life insurance policies or annuity contracts?  Yes  No

Is this insurance applied for intended to replace any existing life insurance policies or annuity contracts?  Yes  No

If either question is answered Yes, please complete a replacement form as prescribed by your state's regulations.

Is this a 1035 Exchange?  Yes  No      Is this an internal term conversion?  Yes  No

SIGNED AT: \_\_\_\_\_

P \_\_\_\_\_  
**Signature of Licensed Agent**

DATED ON: \_\_\_\_\_

\_\_\_\_\_  
**Print Name of Licensed Agent**

SERFF Tracking Number: MCHX-G127678771 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 49936  
 Company Tracking Number: IA-006 (ED. 09-11)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 09-11) Indiv Life Application - Harley  
 Project Name/Number: IA-006 (Ed. 09-11) Indiv Life Application - Harleysville Life Insurance Company/IA-006 (Ed. 09-11) Indiv Life Application - Harleysville Life Insurance Company

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR Readability Certification.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> n/a to this filing <b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Authorization Letter <b>Comments:</b> <b>Attachment:</b> 2011 Harleysville Third Party Authorization Letter.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability <b>Comments:</b> <b>Attachment:</b> Generic Statement of Variability.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> AR Compliance - Rule 49 <b>Comments:</b>		

SERFF Tracking Number: MCHX-G127678771 State: Arkansas  
Filing Company: Harleysville Life Insurance Company State Tracking Number: 49936  
Company Tracking Number: IA-006 (ED. 09-11)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: IA-006 (Ed. 09-11) Indiv Life Application - Harley  
Project Name/Number: IA-006 (Ed. 09-11) Indiv Life Application - Harleysville Life Insurance Company/IA-006 (Ed. 09-11) Indiv Life Application - Harleysville Life Insurance Company

**Attachment:**

AR Cert of Compl 23-79-138 & RR 49.PDF

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** AR Compliancer Rule 19

**Comments:**

**Attachment:**

AR Cert of Compl with Rule 19.PDF

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** GAN-009 (AR) (Ed. 01-04)

**Comments:**

**Attachment:**

GAN-009 (AR) (Ed\_ 01-04) Guaranty Assoc Notice-AR.PDF

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** LFEA-138 (Ed. 10-09)

**Comments:**

**Attachment:**

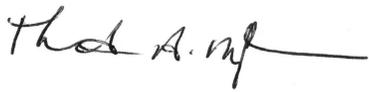
LFEA-138 (Ed\_ 10-09) ARK Notice to Policyholders.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** Harleysville Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
IA-006 (Ed. 09-11)	51
IA-007 (Ed. 09-11)	50
IA-008 (Ed. 00-11)	48

Signed:   
Name: Theodore A. Majewski  
Title: President and Chief Operating Officer  
Date: 10/03/11

**Harleysville Life Insurance**  
355 Maple Avenue  
Harleysville, PA 19438-2297  
www.harleysvillelife.com

Tel 800.222.1981  
215.513.6400  
Fax 215.513.6410



January 3, 2011

NAIC Company Code: 64327

Re: Attached Filing Submission

Please accept this letter as authorization from Harleysville Life Insurance Company for McHugh Consulting Resources, Inc. to file any or all policy forms as well as actuarial materials as referenced in the corresponding SERFF filing on behalf of Harleysville Life Insurance Company.

Sincerely,

A handwritten signature in black ink, appearing to read "Theodore A. Majewski". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Theodore A. Majewski  
President and Chief Operating Officer  
Harleysville Life Insurance Company

**HARLEYSVILLE LIFE INSURANCE COMPANY  
STATEMENT OF VARIABILITY**

**IA-006 (Ed. 09-11)**

**IA-007 (Ed. 09-11)**

**IA-008 (Ed. 09-11)**

*The following items on the Forms are bracketed and considered variable.*

**All Forms**

**Page 1**

Company address, telephone number and web address could change in the future.

Blanks provided in the forms will be completed by the proposed insured, applicant or agent where appropriate.

**Form IA-006 (Ed. 09-11), Application for Individual Life Insurance**

**Section IV Payment**

We may add a Credit Card billing method in the future.

**Page 2**

**Section V Plan of Insurance**

Applicable Riders may be discontinued on certain plans in the future or may not be available in all states.

**CERTIFICATE OF COMPLIANCE**

Insurer: **HARLEYSVILLE LIFE INSURANCE COMPANY**

Form Numbers:

**IA-006 (Ed. 09-11), et al. – Application for Individual Life Insurance**

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



\_\_\_\_\_  
Signature of Company Officer

\_\_\_\_\_  
Theodore A. Majewski

Name

\_\_\_\_\_  
President and Chief Operating Officer

Title

\_\_\_\_\_  
10/03/11

Date

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: **HARLEYSVILLE LIFE INSURANCE COMPANY**

Form Number(s): **IA-006 (Ed. 09-11), et al. – Application for Individual Life  
Insurance**

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



\_\_\_\_\_  
Signature of Company Officer

Theodore A. Majewski  
\_\_\_\_\_

Name

\_\_\_\_\_  
President and Chief Operating Officer

Title

10/03/11  
\_\_\_\_\_

Date

## **LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

### **DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life and variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the ACT; nor does it in any way change anyone's rights or obligations under the ACT or the rights or obligations of the Guaranty Association.

### **COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as will, even if they live in another state.

### **EXCLUSIONS FROM COVERAGE**

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certification was issued):
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals).
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**HARLEYSVILLE LIFE INSURANCE COMPANY**  
Harleysville, Pennsylvania

**FOR POLICIES ISSUED IN ARKANSAS**

Issued by Harleysville Life Insurance Company to the Policyholder.

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Harleysville Life Insurance Company  
355 Maple Avenue  
Customer Relations Department  
Harleysville PA 19438  
1-800-222-1981

Policyholder Service Office of Company: Harleysville Life Insurance Company

Address: 355 Maple Avenue Harleysville, PA 19438

Telephone Number: 1-800-222-1981

Name of Agent: \_\_\_\_\_

Address: \_\_\_\_\_

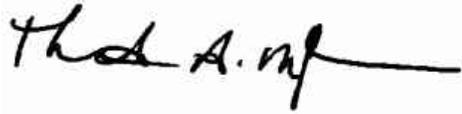
Telephone Number: \_\_\_\_\_

If we at Harleysville Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
(501) 371-2640 or (800) 852-5494



Robert A. Kauffman  
Director and Secretary



Theodore A. Majewski  
President and Chief Operating Officer